

NOTICE OF INDEPENDENT REVIEW DECISION

March 21, 2003

RE: MDR Tracking #: M2-02-0761-01
IRO Certificate #: IRO4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ____ when she injured her lower back. An MRI performed on 10/30/00 revealed degenerative changes of the disc at the L4-5 level with no evidence of disc herniation, spinal stenosis or foraminal compromise. An MRI performed on 03/08/02 revealed a 1mm posterior bulge at L4-5 and a 1mm posterior bulge at L5-S1. Electromyography/Nerve Conduction Studies (EMG/NCS) were performed on 05/02/01 and revealed evidence consistent with mild chronic bilateral L5 nerve root irritation, partial chronic denervation and mild radiculopathy, more prominent on the right. The patient continues to complain of muscle spasms, tenderness, and pain in the lumbar spine and the treating physician has recommended that the patient undergo radio frequency (RF) lesioning of the bilateral lumbar facet joint and bilateral sacroiliac joint as an outpatient.

Requested Service(s)

RF lesioning of the bilateral lumbar facet joint and bilateral sacroiliac joint as an outpatient

Decision

It is determined that the RF lesioning of the bilateral lumbar facet joint and bilateral sacroiliac joint as an outpatient is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is inadequate physical examination evidence to implicate the facets as a primary pain generator. The MRI also does not support the diagnosis of facet arthropathy. In addition, there is inadequate evidence in the literature to support RF lesioning of the sacroiliac joints. Studies indicate varied and extensive intervention of the sacroiliac joints that is not amenable to RF lesioning. Therefore, the radio frequency lesioning of the bilateral lumbar facet joint and bilateral sacroiliac joint as an outpatient are not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of March 2003.